Co-design Partners in Care case study

Pacific ASH 0-4 (Hutt Valley District Health Board)

Context

In the Hutt Valley, Ambulatory Sensitive Hospitalisations[1] (ASH) create a significant burden on the health system, and indicate a system issue where conditions that could potentially be managed in primary and community care are not being managed at this level of the system. Not only does this create a significant burden for secondary services, but acute health situations and avoidable admissions are stressful for individuals and families.

Of particular concern is Hutt Valley District Health Board (DHB)'s poor performance on ASH for 0-4 years, most notably the DHB's Pacific ASH 0-4 year rates. As figure 1 below indicates, the DHB's Pacific ASH 0-4 year rates are nearly double those of the national average. These figures are some of the worst in the country. It is encouraging to observe the trend changing over time, although the rate of change over the 12 months to December 2016 has levelled out significantly.

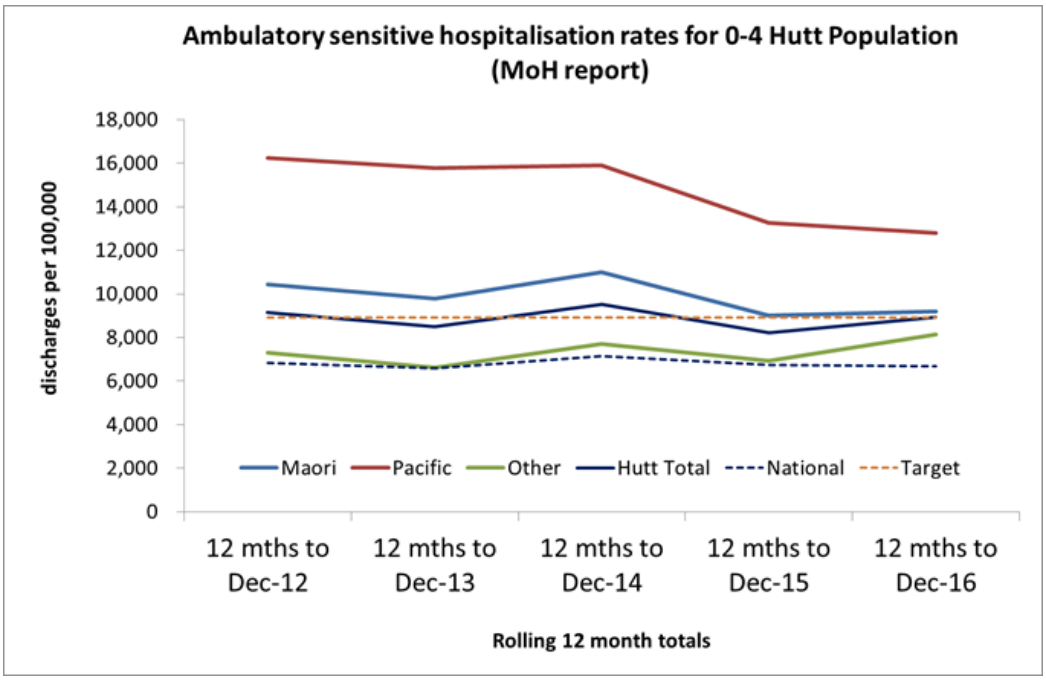

Figure 1

The Government is focused on DHB performance against ASH rates. Each year targets are set for the 0-4 years population, most recently through System Level Measure Improvement work. This work sits across secondary and primary services.

At Hutt Valley DHB, a number of initiatives are underway which are focused on decreasing ASH rates, particularly in children. Most of the top ASH conditions across all age groups are respiratory conditions. A major piece of work, entitled the 'Respiratory Patient Journey', is being undertaken by services across the DHB. The work began with a review of respiratory services provided by the DHB and put forward a number of recommendations to support better respiratory management across the system. Patients were involved in the initial review and clinical networks across

[1] ASH are mostly acute admissions that are considered potentially reducible through prophylactic or therapeutic interventions deliverable in a primary care setting. ASH conditions include respiratory, gastroenteritis, dental and skin conditions.

community, primary and secondary services supported the way forward. Some of the initiatives are targeted at children, although none is specifically focused on the Pacific community.

Aim

The aim of this project was to understand the journey of Pacific families with children who have one or more ASH attendance to hospital. The group endeavoured to understand what the experience was like for these families and support them to identify where there are gaps and opportunities.

Gaps and opportunities were also identified for this work to feed into wider DHB work, such as the 'Respiratory Patient Journey' highlighted above.

Engage

We recognised the importance of senior leadership support right at the beginning of our project and were fortunate to engage a member of the DHB's executive leadership team in our co-design team. We also engaged key senior stakeholders (such as the chief executive officer of Te Awakairangi Heath Network), and developed strong links with the provider, funder and primary care arm of Hutt Valley DHB.

As the focus for the project was around Pacific families, we approached families in an identified 'church cluster' (part of a wider Pacific Health initiative). The two consumers involved were highly engaged in the process and very keen to share their experience to help the systems improve.

Primary health organisation (PHO) staff engaged with Pacific community based groups, and hospital staff were involved and able to share their opinions which were incorporated in the capture phase.

Capture

As outlined above, the DHB has a good understanding of ASH presentations in children aged 0-4 years and these were considered as the project started. Following this, the group systematically captured experiences in three ways:

1) Detailed stories from two consumers who had recently been through an experience to access urgent care for their child.

2) Through broader discussions with Pacific community based groups.

3) By discussion with staff working in the ED.

1) Consumer representative: Stories were captured by listening to and recording the journeys experienced. The captured stories were then reviewed by the consumers to ensure they were captured correctly. Two consumers were largely involved in this process – a mother of a one year old boy and a father of seven, with two children under four. A generic 'storyboard' (Figure 2) was used to capture the experience in pictures.

2) Wider Pacific community engagement: PHO staff went to Pacific community based groups and informally asked about experiences with young children attending the Emergency Department (ED). General themes were captured in speech bubbles (figure 3).

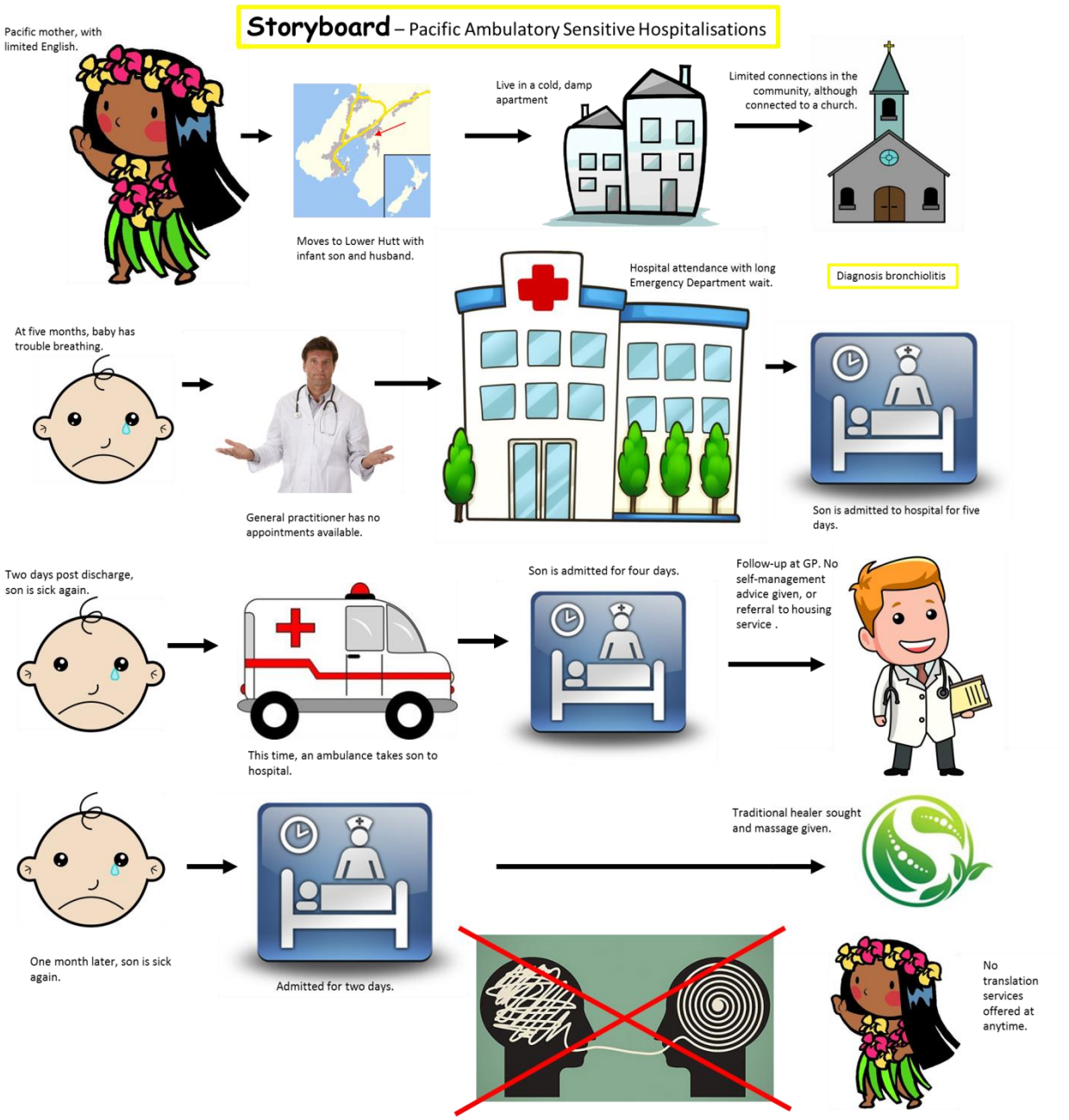

Figure 2

I ring Plunket Line when I need information about a condition my child has or I have concerns about my child (Samoan mother with 6 month old baby)

The first people I go to for health information are my friends, family and then GP. I have only been at hospital once with my child and was put in the Tree Hutt. This is a great place to have children. My experience was ok at the hospital. I didn't have to wait long.

Figure 3

3) Hospital staff engagement: Staff opinions on Pacific families attending ED/hospital were captured on butcher paper in the ED staff room (figure 4) and by email to the after hours duty nurse managers. These were then summarised with common themes in a 'Word Cloud' (figure 5). Feedback from the Paediatrics Department was also sought but none was provided. Of interest, staff in ED did not know the meaning of 'ASH' and what conditions were included in ASH. For a DHB with a large focus on preventing ASH attendances, this focus (and work undertaken to reduce ASH rates) appears not to have been communicated appropriately to ED staff.

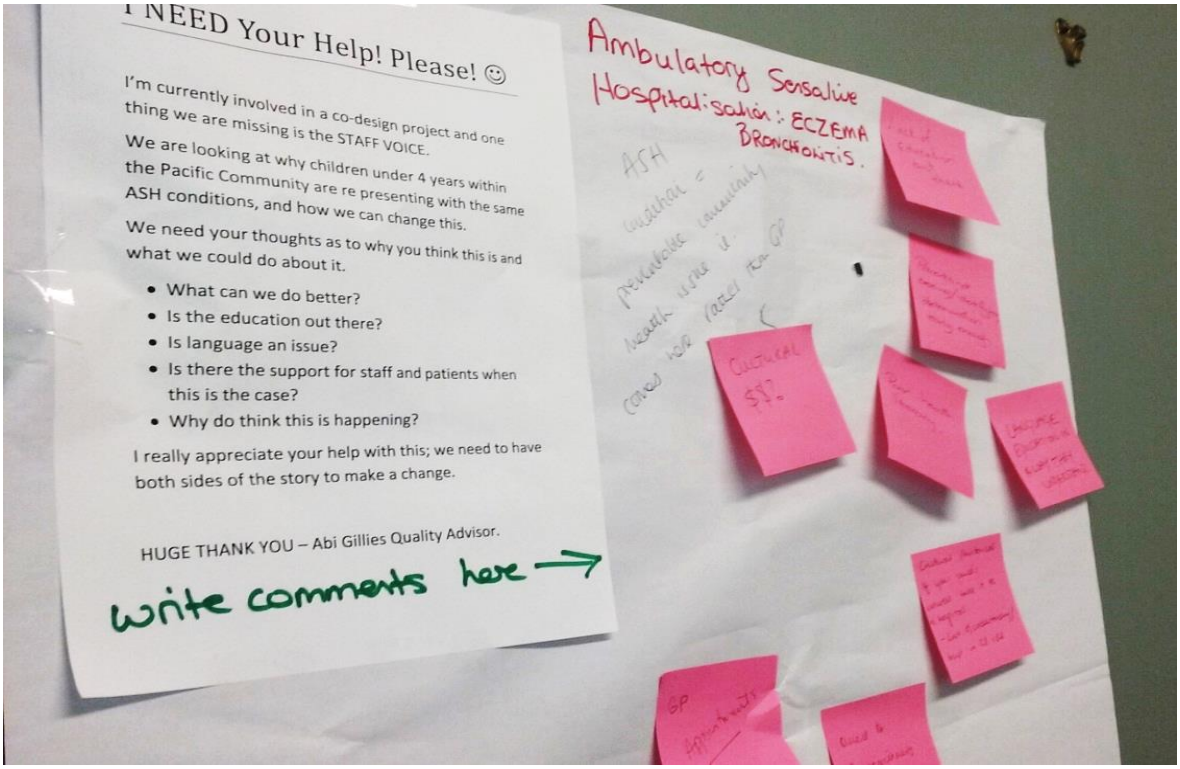

Figure 4

Staff comments are represented in the following word cloud:

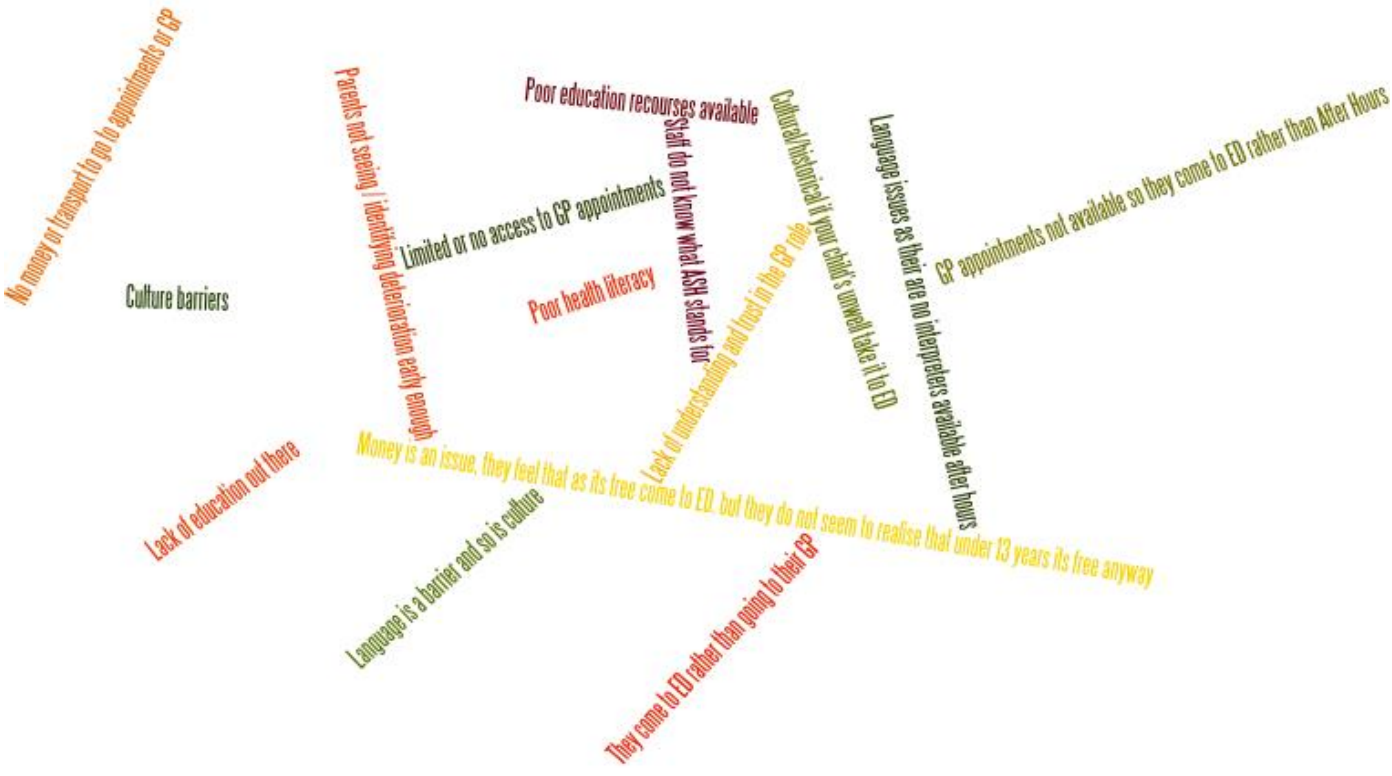

Figure 5

Finally, DHB staff facilitated a second conversation with the two key consumer representatives (see point 1 above.) to identify opportunities for improvement. These opportunities were recorded in minutes, with key highlights as follows:

- **ED experience**: Children are treated like adults (waiting together) and there is no communication on expected wait times.
- **Language**: No one in the system asks about language and understanding. No translation is offered.
- **Self-management**: There is little support for self-management, besides Google.
- **Health literacy**: Translated resources would be helpful, as well as information on the television in the children's ward.
- **General practice availability**: Same day appointments are very important for families.

Understand

It was clear through our engagement with Pacific parents and communities, as well as ED and after-hours duty nurse managers, that neither side (consumer or health provider) felt that the system is appropriately addressing the needs of Pacific families with young children. Both consumers and health providers raised health literacy as a concern, as well as the availability of primary care and community services. Hospital staff raised concern with underlying social matters and the impact this has on the health of the Pacific community and children ('poverty breeds illness'). In conversations with key consumer representatives, lack of translation services was a real concern.

While hospital services can, and should, be more accommodating and culturally appropriate for young Pacific children, we believe that this will not fully address the DHB's high Pacific ASH 0-4 year rates. Both this case study and other work undertaken in Hutt Valley and across New Zealand indicates that high rates can only be improved by supporting better living standards for Pacific people (including warm, dry housing), better community and primary care health system engagement (right services at the right time, in understandable ways), in a way that is easily understood and supports broader health literacy of the community.

Improve

Through this project we have endeavoured to capture the experience of our Pacific families through the health system in Hutt Valley. In addition, we have sought to capture the experience of hospital staff interfacing with Pacific families. Following this engagement, as a group, and with our consumer representatives, we sought to highlight opportunities for improvement in the system. These opportunities were identified/captured (see above) and are feeding into the following DHB work programmes:

- **ED experience/general practice availability:** Hutt Inc (Hutt Valley DHB's Alliance Leadership Team) is overseeing work on acute paediatric flow across both primary and secondary care services. It is intended that this work will drive the following changes:
  - General practice availability for same day appointments – contractual models are changing to support general practice maintaining acute appointment availability.
  - ED post-triage children will be moved out of the adults waiting room, into a room away from adult patients and designed for children's play.
  - Hutt Valley DHB's Children's Assessment Unit (CAU) will be co-located in ED. The CAU will be staffed by a paediatric nurse and registered medical officer. This change will support paediatric flow through ED.
- **Language:** Hutt Valley DHB is in negotiations surrounding its contract with Language Line. Through discussion, it is understood Language Line is not available to staff out of standard

office hours. The DHB is looking at options for translation services to be available during nights and weekends.

- **Self-management and health literacy:** As outlined above, the DHB is undertaking a large initiative to address the management of respiratory conditions across the Hutt Valley health system. This includes a stocktake of self-management and health literacy resources. This co-design Pacific ASH 0-4 years project has highlighted a number of concerns with self-management and health literacy resources for Pacific families, particularly around respiratory conditions. The consumer information gained is informing the stocktake being undertaken through the respiratory project. Any learning from this initial exercise (focused on respiratory), will be carried forward into other ASH areas, particularly dental and gastroenteritis.

In addition, the Pacific Health Unit at Hutt Valley DHB is considering options for discharge support for Pacific families on the Paediatrics ward. The Pacific Health Unit will work to support the transition of the child and family to a primary care provider and/or Pacific provider with information they need to have for appropriate follow up in the community.

The work undertaken as part of the Partners In Care Co-Design programme will support the above work streams, informing ways forward. In addition to the specific projects/work streams listed above, this work will be presented to the DHB's Child Health Network, a group of clinicians and managers working across primary, secondary and community services. It is expected the key findings from the group's consumer engagement will support the wider work of this group, as they work across the system to address disparities experienced by young Pacific children.

Working as a co-design team

The project's co-design team included DHB staff representatives (Pacific, Strategy & Planning and Quality) and PHO staff, working alongside two consumers. The experience supported strong working relationships and a clear process for engaging members of the community in co-design. The group benefited from shared experience/knowledge, as well as the opportunity to work with consumers to understand gaps and opportunities in the Hutt Valley health system. Consumer feedback indicated that they appreciated the opportunity to provide feedback on the system and the experience of their families, as well as opportunities they see for improvement.

In some cases, DHB and PHO staff had worked closely with consumers previously in co-design. The co-design process supported the learning of this previous work and provided a structure for work going forward. In addition, it supported the DHB to clarify its processes for working with consumers (including payment processes etc). This is valuable learning. In particular, the capture phase and tools outlined by the co-design process were helpful for future co-design.

At times, it is tempting to undertake system planning and projects without consumer input, believing ourselves, as health professionals, to be well informed of the issues and concerns of consumers. We found that through the co-design processes, many of our understandings aligned with those of the consumer. However, the importance of individual points or conclusions varied and, at times, the premise of concern was entirely different. This is a timely reminder that the voice of the consumer should not be lost in the busy work of running a health system. In particular, the voice of vulnerable consumers (in our case, Pacific families with young children) is an important and equally valuable input into planning exercises.

Measure

This project and the consumer experience captured is informing significant Hutt Valley health system work. It is the intention of the team that this work not be lost, but be filtered into wider DHB/PHO projects, and through to clinicians and managers working across the system.

Following each of the projects identified in the 'improve' portion of the project, there will be an evaluation of the project, including its impact on our Pacific families. We hope to continue to improve the experience of Pacific families in the health system, and continue to drive down the rates of Pacific ASH in the 0-4 age group. Change in Pacific ASH 0-4 year rates over the next year

or two will ultimately, in part, reflect the work of this project and be a measure of the success of the work.

The project team

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(Note: For privacy, consumer representative's contact information is not shared at their request)